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In the Matter of	:	Date Issued: Oct. 23, 2000
	:	
ELLETHA V. STANFORD, Surviving Spouse of WORLEY C. STANFORD, Dec'd.,	:	Case No.: 1999-BLA-00761
Claimant,	:	
	:	
vs.	:	
	:	
JEWELL SMOKELESS COAL CORP./ DOMINION COAL CORP.,	:	
Employer,	:	
	:	
and	:	
	:	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS	:	
Party-in-Interest.	:	

Lawrence L. Moise, III, Esq.
For the Claimant

Russell Vern Presley, II, Esq.
For the Employer

BEFORE: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

Statement of the Case

This proceeding involves both a modification of a deceased miner's claim and a survivor's claim for benefits under the Black Lung Benefits Act, as amended, 30 U.S.C. §§901 *et seq.*

(hereinafter "the Act") and regulations promulgated thereunder.[1] The Claimant is the miner's widow, who is prosecuting the miner's claim as administratrix of his estate, and who is also prosecuting her own survivor's claim. The Act and regulations provide compensation and other benefits to coal miners who are totally disabled due to pneumoconiosis and their dependents, and to dependent survivors if a miner's death was due to pneumoconiosis. The Act and regulations define pneumoconiosis ("black lung disease" or "coal workers' pneumoconiosis") as a chronic dust disease of the lungs and its sequela, including respiratory and pulmonary impairments arising out of coal mine employment, including any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. §718.201.

The miner's claim was originally filed on November 20, 1980. It was heard and denied by Judge McElroy on August 22, 1988. Judge McElroy concluded that the miner had proved neither the existence of pneumoconiosis nor a totally disabling respiratory or pulmonary impairment. The Benefits Review Board affirmed on October 29, 1990. The miner filed a timely request for modification, which was denied by Judge Murty on January 22, 1993, after a second hearing, finding the evidence insufficient to establish the presence of pneumoconiosis or a totally disabling respiratory or pulmonary impairment, and no change in conditions or mistake in a determination of fact. The miner did not appeal. But on January 20, 1994, he filed another timely request for modification, which was denied after a third hearing by Judge Murty on August 9, 1996. Judge Murty held that the miner had not established either the existence of pneumoconiosis or total disability due to pneumoconiosis. On appeal the Board affirmed the finding of no pneumoconiosis, but held that the judge's finding of total disability under § 718.204(c)(4) was tantamount to a change of conditions and remanded for a determination of entitlement based on a review of the entire record to determine whether there was rebuttal of the presumption under §718.305.

On remand Judge Murty again denied benefits on January 15, 1998, implying that the existence of pneumoconiosis was unproved and holding that the miner was not totally disabled by pneumoconiosis. He found Dr. Castle's 48-page review of all the evidence of record most persuasive, and noted that it was supported by the opinions of Dr. Scott, the miner's treating physician since 1980, and Drs. Garzon, Stewart, and Sargent, who, like Dr. Castle, are board-certified in pulmonary medicine, and Dr. Endres-Bercher, who is board-certified in internal medicine, to the effect that the miner, though probably disabled by his pulmonary condition, did not suffer from pneumoconiosis or any other disease of the lung caused by exposure to coal dust. Judge Murty credited the miner with over 24 years of coal mine employment ending in May 1980, and found that the miner last worked as a section foreman, which required significant hard labor.

An appeal to the Board was aborted by the miner's death on August 10, 1998, and a request for remand on August 27, 1998, to consider another request for modification based upon the autopsy report, averred a mistake in a determination of fact. (DX 168, 175, 177) Claimant requested a

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[1] All applicable regulations which are cited are included in Title 20 of the Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Director's Exhibits are indicated as "DX", Transcript of the Hearing is indicated as "TR", Claimant's Exhibits are indicated as "CX", and Employer's Exhibits are denoted "EX."

hearing after the denial on November 24, 1998, by the District Director of the Claimant's request for modification on behalf of the deceased miner and the January 13, 1999, denial of her survivor's claim filed December 16, 1998. (DX 182, 185, 190) After referral on March 31, 1999, a fourth hearing was conducted on August 25, 1999, and the claims are now before me for decision. (DX 210)

At the hearing, Director's Exhibits one (1) through two hundred ten (210), Claimant's Exhibits one (1) through two (2), and Employer's Exhibits one (1) through twenty (20) were received into evidence. The Employer was given thirty days in which to procure a physician's report in response to CX 1 and 2, and the Claimant was also given thirty days to procure a report from Dr. Emory Robinette (TR 12-16, 25). Pursuant to my order dated October 5, 1999, the Claimant was given until October 27, 1999 in which to file post hearing evidence. Dr. James Castle's report dated September 22, 1999, was received on September 27, 1999, and is admitted into evidence as EX 21. Dr. Robinette's report dated September 21, 1999 and his curriculum vitae were received on October 4, 1999 and are admitted into evidence as CX 3 and CX 4, respectively. The record is now closed. The parties were given until September 25, 1999, in which to submit closing arguments in writing, (TR 26), but pursuant to my order dated October 26, 1999, they were granted until November 26, 1999 in which to file briefs. The Claimant's brief was received on December 2, 1999, and the Employer's brief was received on December 7, 1999.

Because the miner was last employed in the state of Virginia, the law of the Fourth Circuit Court of the United States controls. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (*en banc*). Since the miner and the Claimant filed their respective applications for benefits after March 31, 1980, Part 718 applies.

ISSUES

1. Whether the evidence establishes a change in conditions since Judge Murty's denial of January 15, 1998?

2. Whether review of all the evidence of record discloses a mistake in the determination of any fact pursuant to § 725.310?

3. Whether the survivor's claim was timely filed?

4. Whether the miner's request for modification was validly filed?

5. Whether the miner had coal workers' pneumoconiosis?

6. Whether the miner's pneumoconiosis, if proved, was caused by his coal mine employment?

7. Whether the miner was totally disabled?

8. Whether the miner's total disability was due to pneumoconiosis?

9. Whether the miner's death was due to pneumoconiosis?

The Employer also challenged the constitutionality of the Act and Regulations by way of the controversion of other related issues. Such issues of constitutionality are beyond the jurisdiction of administrative agencies. *Oestereich v. Selective Service System Board No. 11*, 393 U.S. 233, 242 (1968) (Harlan, J., concurring); *Public Utilities Comm'n v. United States*, 355 U.S. 534, 539 (1958).

FINDINGS OF FACT, DISCUSSION, AND CONCLUSIONS OF LAW

Timeliness of Filing and Requirement for Review of Merits of Claims

Because there is no time limit on the filing of a claim by the survivor of a miner, the instant survivor's claim is timely filed. §725.308(a). It is also settled law that repeated timely requests for modification under § 725.310(b) are not precluded by rules of finality or limitations. *See Garcia v. Director, OWCP*, 12 BLR 1-24 (1988). The instant request for modification is timely and properly filed. Because both the autopsy prosector and Dr. Naeye, the board-certified pathologist who reviewed the autopsy slides and medical records, have with unimpeached credibility established the existence of simple pneumoconiosis, Claimant has established the requisite premises for a comprehensive review of the entire record with respect to the merits of the miner's claim. *See Nataloni v. Director, OWCP*, 17 BLR 1-82, 1-84 (1993); *Kovac v. BCNR Mining Corp.*, 14 BLR 1-156 (1990); *see also Jessee v. Director, OWCP*, 5 F.3d 723, 18 BLR 2-26 (4th Cir. 1993). The survivor's claim is subject to consideration *de novo*.

Background

The miner, Worley C. Stanford, was born on March 22, 1935 and died on August 10, 1998 (DX 190). His wife, Elletha Stanford, the Claimant, whom he married on October 22, 1954, was born on October 25, 1936. Claimant testified that she and the miner were living together at the time of his death, and she has not remarried (TR 17-18). The miner was a lifetime non-smoker (TR 18). Claimant stated that the miner's clothes would be black with coal dust when he returned home from work (TR 19). His primary treating physician was Dr. Scott, whom he'd seen for the last fifteen to sixteen years of his life (TR 19). He used an inhaler and nebulizer, and eventually was placed on oxygen (TR 20). At first he used the oxygen intermittently, but Dr. Scott put him on it continually about one and a half years before his death (TR 21). The miner died in the hospital and had trouble breathing just before he died (TR. 21).

Length of Coal Mine Employment

In the previous decisions, the miner was credited with more than 24 years of coal mine employment. The Employer did not appeal the length of coal mine employment to the Benefits Review Board, which affirmed the finding as unchallenged. *Skrack v. Island Creek Coal Co.*, 6 BLR 1-710 (1983). Accordingly, I find that the miner qualifies as a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations for at least 24 years. His last job was as a section foreman which required him to crawl and occasionally spell the miners in his crew. He last worked in May 1980.

Responsible Operator

Jewel Smokeless Coal Corporation, the successor corporation to Dominion Coal Corporation, is the responsible operator liable for payment of any benefits which may be found to be due (TR 5-6).

Finding of Fact - Medical Evidence

The medical evidence submitted since Judge Murty's January 15, 1998 Decision and Order Denying Benefits is set forth below. Of this newly submitted evidence, only that medical evidence created after January 15, 1998, the date of the last denial, is relevant to whether there has been a change of conditions pursuant to §725.310.

Chest X-ray Evidence[2]

Exh. No.	Date of X-ray	Date of Report	Physician/ Qualifications	Diagnosis
DX 204	8/17/95	8/17/95	Prminski	Stable chronic interstitial and linear density in both lungs with cardiomegaly.
EX 17	3/27/96	3/30/96	Peterkin/R	No pleural effusions or pneumothorax
EX 16	4/29/96	4/30/96	Peterkin/R	No pleural effusions or pneumothorax
EX 14	9/6/96	9/8/96	Peterkin/R	No definite acute intrathoracic abnormality
EX 14	9/6/96	9/10/96	Naik/R	Mild to moderate congestive failure; no significant pleural effusions
EX 14	9/6/96	9/10/96	Peterkin/R	Interstitial pulmonary edema.
DX 203	11/19/96	11/19/96	Fajardo/R	Bibasilar subsegmental atelectasis; no evidence for pneumothorax.
DX 203	11/20/96	11/20/96	Wallace/R	Interstitial edema; some bilateral compression atelectasis
DX 203	11/21/96	11/21/96	Wallace/R	Pattern of pulmonary edema and atelectasis remains unchanged

[2] The following abbreviations are used in describing the qualifications of the physicians: B = B-Reader and R = Board-Certified Radiologist. Although the credentials of these physicians are not in the record, I have taken judicial notice of their qualifications according to www.certifieddoctor.com and the 2000 NIOSH B-reader list. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 BLR 1-135 (1990).

DX 204	8/7/97	8/7/97	Crawford/R	Small left pleural effusion; mild cardiomegaly.
EX 8	8/9/97	8/11/97	Naik/R	Persistent areas of atelectasis/patchy type consolidation in the lingula; small granulomas in left lower lung.
EX 8	9/20/97	8/21/97	Naik/R	Small bilateral effusions.
EX 5	2/12/98	2/12/98	O'Donohue/R	Partial clearing of bilateral infiltrates last seen on 1/6/98.
EX 5	2/14/98	2/16/98	Naik/R	Persistent areas of atelectasis in the right mid and lower lung regions
EX 4	3/18/98	3/18/98	O'Donohue/R	Cardiomegaly with evidence of previous sternal splitting surgery and central catheter in place; persistent parenchymal infiltrates and bilateral pleural reaction which is extensive on the right side.
DX 204	4/2/98	4/2/98	Crawford/R	Congestive heart failure
EX 1	8/9/98	8/19/98	O'Donohue/R	Mild improvement of bilateral infiltrates consistent with partial clearing of pulmonary edema.

Pulmonary Function Studies

No new pulmonary function studies since the last denial on January 15, 1998 have been submitted. Pulmonary function studies dating from March 31, 1981 to September 5, 1995 are summarized below:

Exh. No.	Test Date	Doctor	Co-op/Undst/TR[3]	FEV1	FVC.	MVV	Qual.[4]	Hgt[5]

[3]Conforming reports of pulmonary function studies must record the miner's level of cooperation and understanding of the procedures, and include three tracings of the maneuvers performed.

[4]Values listed are those values obtained pre-bronchodilator. However, the second line of values shown for the October 23, 1992, May 7, 1993, June 21, 1994, October 17, 1994, June 26, 1995, and September 5, 1995 studies indicate post-bronchodilator studies.

[5]Because of the various heights noted by the examining physicians, I have chosen to resolve the discrepancy by taking the average of the heights recorded. *See Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983). In this case, the average is 65.769 inches.

DX 9	3/31/81	Baxter	–/–/Yes	2.87	–	112	No	67"	
DX 25	7/9/81	Buddington	Good/Good/Yes	3.12	3.61	117	No	65"	
DX 26	9/30/82	Garzon	Good/–/Yes	2.45	2.88	67.2	No	66"	
DX 40	3/31/87	Endres-Bercher	Good/Good/Yes	1.44	1.60	66	Yes	66"	
DX 54	8/5/91	Robinette	Good/–/Yes	2.02	2.07	62	No	67"	
Validation: Found invalid by Dr. Renn on 10/15/91 (DX 65).									
DX 61	10/8/91	Endres-Bercher	Fair/Fair/Yes	1.87	2.10	96	No	64"	
DX 92	10/23/92	Rasmussen	Good/Good/Yes	2.27	2.83	127	No	65"	
				2.40	2.73	125	No		
DX 112	5/7/93	Forehand	Good/–/No	2.12	2.50	88	No	65"	
				2.17	2.49	74	No		
DX 104	6/21/94	Modi	Good/–/Yes	1.61	1.87	54.5	Yes	67"	
				1.74	2.00	53.5	No		
Validation: Found invalid by Dr. Renn on 9/7/94 (DX 111).									
DX 117	10/17/94	Sargent	–/–/Yes	1.89	2.12	40	No	66"	
				1.98	2.21	–	No		
DX 128	6/12/95	Stone Mountain Health Services	Good/–/Yes	1.49	1.63	75	Yes	67"	
DX 134	6/26/95	Forehand	Sat./–/Yes	1.87	1.89	49	No	66"	
				1.83	2.18	61	No		
DX 144	9/5/95	Castle	Good/Good/Yes	1.66	1.94	–	Yes	64"	
				1.78	1.97	–	No		

Arterial Blood Gas Studies

The blood gas studies submitted after and performed prior to and after Judge Murty's January 15, 1998 denial are summarized below:

Exh. No.	Test Date	Doctor	Condition	pCO2	pO2	Alt.	Qualify
DX 12	3/31/81	Baxter	resting	36.6	76.1	0-2999	No
			after exercise	34.9	89.9	0-2999	No

DX 25	6/30/81	Baxter	resting	36.1	80.8	0-2999	No
DX 13	7/9/81	Buddington	resting	35	62	0-2999	Yes
DX 26	9/30/82	Garzon	resting	34.1	59.8	0-2999	Yes
			after exercise	35.2	64.1	0-2999	Yes
DX 34	4/21/86	Robinette	resting	33.4	85.6	0-2999	No
DX 40	3/31/87	Endres-Bercher	resting	41.8	56.3	0-2999	Yes
DX 54	8/5/91	Robinette	resting	40.5	71	0-2999	No
DX 61	10/8/91	Endres-Bercher	resting	34.2	69.8	0-2999	No
DX 92	10/23/91	Rasmussen	resting	38	78	0-2999	No
			after exercise	36	76	0-2999	No
DX 93	6/25/92	Modi	resting	38.1	67.5	0-2999	No
DX 112	5/7/93	Forehand	resting	39	73	0-2999	No
			after exercise	36	80	0-2999	No
DX 104	6/20/94	Modi	resting	45.4	53.4	0-2999	Yes
DX 104	6/21/94	Modi	resting	43.3	57.4	0-2999	Yes
DX 117	10/17/94	Sargent	resting	39.4	69.8	0-2999	No
DX 204	6/1/95	Scott	resting	42	68	0-2999	No
DX 134	6/26/95	Forehand	resting	41	67	0-2999	No
			after exercise	39	70	0-2999	No
DX 144	9/5/95	Castle	resting	41.1	61	0-2999	No
DX 183	1/6/98	Scott	resting	49.8	39.1	0-2999	Yes
DX 183	6/3/98	Scott	resting	71.2	71.4	0-2999	Yes
DX 183	6/3/98	Scott	resting	69.1	48.9	0-2999	Yes
DX 183	8/9/98	Scott	resting	57.3	67.4	0-2999	Yes

The four most recent studies were performed after January 15, 1998, and more than two years after the next prior studies and are qualifying.

Medical Reports/Opinions

The record contains certain medical records and physicians' opinions which were submitted after Judge Murty's denial of dated January 15, 1998. The evidence pertaining to the miner's hospitalization at Clinch Valley Medical Center beginning on February 10, 1998 and subsequent medical records are new evidence pertinent to a change in condition. The evidence includes office notes and progress reports from Dr. Howard C. Scott from June 1, 1995 through July 28, 1998 (DX 204). A review of these records shows that Dr. Scott followed up the miner in connection with his myriad hospital visits which are outlined below. The notes show that the miner sometimes had rales, rhonchi, or wheezes in his lungs, but at other times had clear lungs. Dr. Scott never made a diagnosis of pneumoconiosis.

Dr. Scott attended the miner during a hospital stay at Clinch Valley Medical Center which lasted from March 27, 1996 to April 8, 1996 (EX 17). The miner presented with chest pain, dehydration, nausea, and vomiting. After considering a medical history, laboratory work, and a physical examination which showed clear lungs, Dr. Scott diagnosed: (1) uncontrolled diabetes: (2) hyperglycemia; (3) dehydration; (4) unstable angina; (5) chronic recurrent pancreatitis; (6) peptic ulcer disease; (7) hyperlipidemia; and (8) Strongyloides infestation of the intestinal tract.

From April 29, 1996 to May 8, 1996, Dr. Scott again attended the miner at Clinch Valley Medical Center, when he again presented with nausea and vomiting (EX 16). Consideration of a medical history, laboratory work, and a physical examination which showed clear lungs, led to the diagnoses of: (1) abdominal/chest pain due to chronic pancreatitis; (2) diabetes mellitus; (3) arteriosclerotic heart disease; (4) peptic ulcer disease; and (5) hyperlipidemia.

Dr. Scott attended the miner during a hospital stay from June 30, 1996 to July 7, 1996 for chest and abdominal pain (EX 15). He again reviewed the miner's medical history, laboratory work, and a physical examination to ultimately diagnose: (1) diabetes mellitus; (2) abdominal and chest pain secondary to chronic pancreatitis; and (3) hyperlipidemia.

From September 6, 1996 to October 8, 1996, the miner was hospitalized at Columbia Clinch Valley Medical Center, where Dr. Scott attended him (EX 14). The miner underwent a laparotomy and an esophagogastroduodenoscopy performed by Dr. W.C. Hunter. Three other physicians also consulted on his case. Dr. Hunter diagnosed: (1) gastrointestinal bleed; (2) chronic pancreatitis; and (3) diabetes mellitus. Dr. Scott added the findings of: (1) recurrent pancreatitis; (2) arteriosclerotic heart disease; and (3) peptic ulcer disease.

The miner was hospitalized from November 11, 1996 to November 12, 1996, when Dr. Craig Kubik attended him. Dr. Kubik considered the complaints of increased abdominal discomfort, a medical history, an x-ray and other laboratory work, and the results of a physical examination which showed clear lungs. Dr. Kubik diagnosed: (1) upper gastrointestinal bleed most likely due to a small gastric ulcer; (2) chronic pancreatitis; (3) diabetes mellitus; (4) chronic abdominal pain; and (5)

hypertension.

The record contains records from the university of Virginia Health Sciences Center from November 12, 1996 through November 26, 1996 (DX 203). The miner underwent a splenectomy at the hospital because of a thrombosed splenic vein and gastric varices.

From February 16, 1997 to February 22, 1997, Dr. Scott attended the miner at Columbia Clinch Valley Medical Center (EX 12). The results of a physical examination, an x-ray, laboratory work, and presenting complaints of chest and abdominal pain led to the diagnoses of: (1) uncontrolled diabetes mellitus; (2) chest pain and abdominal pain; (3) recurrent chronic pancreatitis; (4) hypertriglyceridemia; and (5) status post splenectomy. Dr. Iosif consulted during this hospitalization and found the miner had good oxygen saturation despite using oxygen at home.

The miner was hospitalized from March 21, 1997 to March 29, 1997 (EX 11). Dr. Scott considered complaints of elevated blood sugar, some nausea, and abdominal pain. Dr. Scott reviewed the results of a physical examination, an EKG, an x-ray, and other laboratory work. He diagnosed: (1) recurrent pancreatitis causing abdominal pain; (2) diabetes mellitus; (3) arteriosclerotic heart disease; (4) gastric varices; and (5) status post splenectomy.

From May 2, 1997 to May 12, 1997, the miner was again attended at the Columbia Clinch Valley Medical Center by Dr. Scott (EX 10). He presented with chest pain, abdominal pain, nausea, and vomiting. Dr. Scott considered the results of a physical examination, an EKG, an x-ray, and other laboratory work to diagnose: (1) acute upper respiratory infection; (2) diabetes mellitus; (3) dehydration; and (4) chronic recurrent pancreatitis.

Dr. Scott attended the miner during a hospital stay from June 13, 1997 to June 19, 1997 (EX 9). He considered complaints of some nausea and dehydration along with severe abdominal pain, a medical history, physical examination results, and laboratory work, and diagnosed: (1) abdominal pain; (2) chronic recurrent pancreatitis; (3) diabetes mellitus; and (4) leukocytosis.

From August 9, 1997 to September 5, 1997, the miner was attended at the Columbia Clinch Valley Medical Center by Dr. Scott, who noted admitting complaints of uncontrolled diabetes. (EX 8) He further considered the miner's extensive medical history, a physical examination which showed clear lungs, an x-ray, and other laboratory work. Dr. Scott diagnosed: (1) uncontrolled diabetes; (2) chronic recurrent pancreatitis; (3) coronary artery disease; (4) pulmonary hypertension with pulmonary edema; (5) cellulitis of right foot; (6) gastric varices; and (7) chronic obstructive pulmonary disease .

On November 7, 1997, Dr. Scott examined the miner at the Columbia Clinch Valley Medical Center (EX 7). He presented with chest pain, and Dr. Scott considered his medical history, laboratory work, and the results of a physical examination which showed scattered rales and rhonchi in both lung fields. He diagnosed: (1) ischemic cardiomyopathy: (2) chest pain; (3) congestive heart failure; and (4) diabetes mellitus.

The miner was hospitalized from December 13, 1997 to December 19, 1997 (EX 6). Dr. Scott again attended him and noted admitting complaints of abdominal pain with nausea. He noted a history that included cor pulmonale, an EKG, an x-ray, and the results of a physical examination which showed a few scattered rhonchi throughout both lung fields. Dr. Scott diagnosed: (1) chest pain with angina pectoris; (2) arteriosclerotic heart disease; (3) chronic recurrent pancreatitis; (4) pulmonary hypertension-cor pulmonale; (5) diabetes mellitus; (6) peptic ulcer disease; (7) gastric varices; and (8) status post splenectomy.

The miner was hospitalized at Clinch Valley Medical Center from February 10, 1998 to February 17, 1998, where he was attended by Dr. Scott (EX 5). Dr. Scott noted admitting complaints of difficulty in the chest and abdominal pain, and considered the results of a physical examination, which revealed somewhat distant tones, a few scattered rhonchi, and wet rales in both lung bases. He also reviewed laboratory data and diagnosed: (1) congestive heart failure; (2) chronic recurrent pancreatitis; (3) diabetes mellitus; (4) arteriosclerotic heart disease; (5) gastric varices; and (6) chronic obstructive pulmonary disease .

From March 11, 1998 to March 26, 1998, the miner was hospitalized at Clinch Valley Medical Center, where he was attended by Dr. Scott. He complained of lethargy, weakness, nausea, and vomiting. After a physical examination, which showed rales in both lung bases, laboratory work, and a physical examination, Dr. Scott diagnosed: (1) congestive heart failure; (2) ischemic cardiomyopathy; (3) diabetes mellitus; (4) recurrent pancreatitis; (5) gastric varices; and (6) leukocytosis.

The miner was hospitalized at Clinch Valley Medical Center from April 2, 1998 to April 24, 1998, where he was attended by Dr. Scott (EX 3). His chief complaints were nausea, vomiting, dehydration, and weakness. Upon examination Dr. Scott examined found a few scattered rhonchi bilaterally, and considered laboratory work, an x-ray, and an EKG. He diagnosed: (1) abdominal pain due to chronic recurrent pancreatitis; (2) dehydration; (3) diabetes mellitus; (4) arteriosclerotic heart disease with pulmonary hypertension and congestive heart failure; (5) anemia; and (6) microscopic hematuria.

Dr. Scott attended the miner from May 9, 1998 to May 30, 1998, when he was hospitalized at Clinch Valley Medical Center (EX 2). Dr. Scott noted complaints of a humerus fracture, a medical history, x-rays, blood work, and the results of a physical examination, which showed a few scattered wheezing rales bilaterally. He made the following final diagnoses: (1) left humerus fracture; (2) left radius fracture; (3) diabetes mellitus; (4) chronic pancreatitis; (5) ischemic cardiomyopathy; (6) pulmonary hypertension; and (7) chronic obstructive pulmonary disease.

Dr. Ramon Motos examined the miner on May 9, 1998 (EX 2). He considered a medical history, and symptoms. He diagnosed: (1) fracture of the left shoulder; (2) uncontrolled diabetes mellitus; (3) ischemic cardiomyopathy; (4) hyperlipidemia; (5) chronic recurrent pancreatitis; and (6) anemia with thrombocytosis.

Medical records from Clinch Valley Medical Center from August 2, 1998 to August 10, 1998

are in evidence. (EX 1). Dr. Larry G. Mitchell attended the miner during this hospitalization, which ended in the miner's death. The miner presented with pain in the lower chest and epigastric area. Dr. Mitchell considered a medical history which was remarkable for cardiomyopathy, pulmonary hypertension, congestive heart failure, acute pancreatitis, diabetes, and renal insufficiency, as well as a history of not smoking and the results of a physical examination which revealed clear lungs but decreased air movement in the bases, EKG's, and the reports of other physicians who consulted on the case. His final diagnoses were: (1) congestive heart failure secondary to dilated ischemic cardiomyopathy; (2) progressive renal failure; (3) chronic pancreatitis; (4) type I diabetes mellitus; (5) hypothyroidism; (6) probably lumbar plexopathy in the lower extremities; (7) seizure disorder; and (8) chronic abdominal pain.

One of the consulting physicians, Dr. Maged J. Farah, an endocrinologist who saw the miner on August 3, 1998, diagnosed uncontrolled diabetes; a history of hyperlipidemia; a history of chronic pancreatitis; coronary artery disease and a history of congestive heart failure; and uncontrolled hypothyroidism. (EX 1)

Dr. Mrugendra R. Patel provided a neurological consultation on August 4, 1998 (EX 1). He noted that the miner smoked in the past but denied any current use. He also considered the results of a physical examination, a medical history, and laboratory work. Dr. Patel diagnosed: (1) probable diabetic ischemic lumbosacral plexopathy; (2) chronic pain and paresthesia in both legs secondary to diabetic polyneropathy; (3) severe hypothyroidism; (4) diabetes mellitus; (5) history of ischemic cardiomyopathy and congestive heart failure; (6) history of chronic pancreatitis; and (7) history of pulmonary hypertension.

On August 10, 1998, Dr. In Park, a nephrologist, examined the miner (Ex 1). He considered 32 years of coal mine employment and was told that the mi9ner had black lung by the miner or his wife. Laboratory results, a medical history, current symptoms, and a physical examination led Dr. Park to diagnose: (1) acute renal failure most likely due to hypotension; (2) hypokalemia; (3) chronic renal failure with possible diabetic nephropathy; (4) congestive heart failure; (5) massive bowel distension; and (6) significant jerking movements of the arms and eyelids.

The miner died on August 10, 1998. His death certificate was signed by Dr. Larry G. Mitchell, who listed the cause of death as congestive cardiomyopathy and arteriosclerotic cardiovascular disease. (DX 191) He listed renal failure, type I diabetes mellitus, chronic pancreatitis, and hypothyroidism as other significant conditions that contributed to the miner's death but were not its underlying cause.

An autopsy limited to the chest was performed on August 11, 1998 by Dr. Larry W. Joyce (DX 192). Dr. Joyce also considered 32 years of coal mine employment, last as a section foreman, a history of never smoking, the miner's medical history, and his most recent hospital course. He performed both a microscopic and macroscopic inspection of the lungs and found brown lung parenchyma and scattered anthracotic pigment deposition. He saw coal macules interstitially and around the bronchioles. His final diagnoses regarding the cardiovascular and respiratory systems included: (1) coronary artery disease; (2) cardiomegaly; (3) atherosclerosis; (4) coal workers' pneumoconiosis with numerous coal macules in all lobes and a few micronodular lesions; (5) acute

and chronic tracheitis; and (4) mild chronic bronchitis. He felt that the immediate cause of death was multi system failure secondary to hypotension resulting from cardiac decompensation secondary to severe coronary artery disease. Dr. Joyce is board-certified in anatomical and clinical pathology[6]. (DX 179).

On April 11, 1999, Dr. Richard L. Naeye, who is board-certified in anatomic and clinical pathology, reviewed the autopsy report, 16 glass slides of the lung tissue removed at autopsy, "many pounds of medical records and opinions," 24 years of coal mine employment, and a history of not smoking (EX 18). Although he found only a few anthracotic macules and micronodules with associated fibrosis and focal emphysema, it was enough to make the diagnosis of simple coal workers' pneumoconiosis. He opined that these lesions were too small and few in number to cause any abnormalities in lung function. He added that the lung impairments the miner suffered from were the result of a paralyzed right hemidiaphragm which is not caused by pneumoconiosis. Dr. Naeye explained that the pulmonary function study results support his conclusions. Dr. Naeye averred that the miner's pneumoconiosis was far too mild to have hastened his death or prevented him from mining coal.

Dr. Grover M. Hutchins reviewed medical evidence on July 18, 1999 (EX 19, 20). He considered 32 years of coal mine employment, most recently as a foreman, a history of never smoking, a medical history, the autopsy report, x-ray readings, pulmonary function studies, and 43 histologic slides, including fifteen containing lung tissue. Dr. Hutchins found a slight to moderate degree of simple coal workers' pneumoconiosis and asthmatic bronchitis. He added, however, that the disease was not of sufficient severity to have contributed to pulmonary or respiratory impairment. He felt that any pulmonary or respiratory impairment was due to congestive heart failure due to ischemic heart disease. Dr. Hutchins added that the miner was totally disabled by his cardiac disease and other medical problems but asserted that neither coal workers' pneumoconiosis nor coal dust exposure played any role in hastening the miner's death. Dr. Hutchins is board-certified in anatomic pathology.

Dr. Scott provided a letter opinion dated July 23, 1999 (CX 1). He explained that he had treated the miner on many occasions over several years. He alluded to 30 years of coal mine employment, and frequent symptoms of a productive cough and shortness of breath. Dr. Scott stated that x-rays revealed evidence of some degree of pulmonary fibrosis, namely chronic obstructive pulmonary disease with associated coal workers' pneumoconiosis, which he felt contributed to the miner's demise.

Dr. J. Randolph Forehand provided a letter opinion dated July 31, 1999 (CX 2). He had examined the miner on June 26, 1995, noting that he was a lifetime non-smoker who had worked as a coal miner for 32 years. He administered a pulmonary function study which he believed evinced a totally disabling obstructive-restrictive respiratory impairment typical of pneumoconiosis. He explained that pneumoconiosis progresses in severity even after exposure ceases and that one of its

[6]According to www.certifieddoctor.com, from which I take judicial notice of physicians' qualifications.

complications is cor pulmonale, which places abnormal stress on the heart and prevents the lungs from transferring oxygen to the body normally, which in turn impairs the function of the heart, kidneys, and brain. Dr. Forehand stated that the miner died from multiorgan failure. Although he asserted that heart disease was the primary cause of death, he opined that pneumoconiosis leading to cor pulmonale also contributed thereto.

Dr. Emory H. Robinette reviewed medical records on September 21, 1999 (CX 3). He reviewed medical records from the period March 27, 1996 through August 11, 1998, including hospital admissions, and a copy of the autopsy report. In July 1995, he had previously reviewed medical records from 1992 through 1994. He concluded that the autopsy established the presence of pneumoconiosis associated with a respiratory impairment severe enough to have left the miner unable to work as a coal miner. Dr. Robinette opined that the disease and intercurrent hypoxemia contributed to the miner's multiple medical problems by worsening his general medical condition and was at least partially responsible for his death. Dr. Robinette is board-certified in internal medicine and pulmonary disease (CX 4).

On September 22, 1999, Dr. James R. Castle reviewed additional medical evidence developed since his September 19, 1995 report (EX 21). He reviewed his previous report and the reports of Drs. Scott and Forehand found at CX1 and 2. Dr. Castle opined that the miner did have pathologic evidence of simple coal workers' pneumoconiosis which could not have caused any significant respiratory impairment. He did not find cor pulmonale. Dr. Castle stressed that the miner did not have respiratory or pulmonary impairment related in any way to coal mine dust exposure or pneumoconiosis. In his opinion, the mild degree of restrictive lung disease was due to cardiac disease, not pneumoconiosis. Still, Dr. Castle opined that the miner did not retain the respiratory capacity to perform his usual coal mining duties because of recurrent pneumonia with pleural effusions, thoracic surgery with injury to the right phrenic nerve and paralysis of the right hemidiaphragm, obesity, and congestive heart failure, but not pneumoconiosis. He found the miner's cause of death was multi-organ failure due to cardiac decompensation related to an acute myocardial infarction in the face of severe coronary artery disease and cardiomyopathy. Dr. Castle opined that the miner's death was neither caused by, contributed to by, or hastened in any way by coal workers' pneumoconiosis, and that the miner would have died at the same time and in the same manner even if he had never been a coal miner. Dr. Castle is board-certified in internal medicine and pulmonary disease.

Conclusions of Law and Discussion

Existence of Pneumoconiosis

Section 718.202(a) provides four bases for finding the existence of pneumoconiosis: (1) a properly conducted and reported chest x-ray; (2) a properly conducted and reported biopsy or autopsy; (3) reliance upon certain presumptions which are set forth in §§ 718.304, 718,305, and 718.306; or (4) findings by a physician of pneumoconiosis as defined in § 718.201 based upon objective evidence and a reasoned medical opinion.

Of the seventeen new x-ray interpretations submitted since the prior denial, only three of the

x-rays were taken after Judge Murty's January 15, 1998, denial, though the x-rays were taken from August 17, 1995 to August 9, 1998. None of the fourteen x-rays was read specifically for the presence or absence of pneumoconiosis. These x-rays were taken during the claimant's myriad hospitalizations. Consequently, neither the newly submitted nor the new x-ray evidence taken after the January 15, 1998, denial, establishes the existence of pneumoconiosis. This is consistent with the overwhelming majority of the prior x-ray evidence of record.

A review of the prior x-ray evidence reveals 132 readings of twenty-eight separate x-rays taken between October 9, 1980 and September 5, 1995. Only six of these twenty-eight films were interpreted as positive for pneumoconiosis. The first was taken on November 3, 1980, and was read as category 2/3 by Dr. Sutherland, who is neither a B-reader nor board-certified radiologist. The film was found unreadable by Drs. Wiot and Felson, and as negative by Drs. Spitz and Poulos, all four of whom are both B-readers and board-certified radiologists. Their readings merit the greatest weight because of their credentials. See *Scheckler v. Clinchfield Coal Co.*, 7 BLR 1-128 (1984).

The next film read as positive for pneumoconiosis was taken on March 31, 1981, and was read by Dr. Gale, who is a board-certified radiologist. However, Drs. Castle, Stewart, and Hippensteel, who are B-readers and Dr. Poulos, who is a B-reader and board-certified radiologist, reread the film as negative. Because Dr. Poulos possesses the greatest qualifications of these five physicians, and because his reading is corroborated by the readings of three B-readers, I find that the negative interpretations prevail.

The May 22, 1981 x-ray was also interpreted as positive by Drs. Gale and Brandon, who is both a B-reader and board-certified radiologist. However, Drs. Spitz and Wiot found this x-ray unreadable, while Drs. Castle, Stewart, Hippensteel, Felson, and Poulos found it negative for pneumoconiosis. The preponderance of negative interpretations by qualified readers must prevail.

The September 21, 1984 x-ray was interpreted as positive by Drs. Gale, Bassali, Westerfield, Williams, Fisher, and Marshall. Of these physicians, Drs. Gale, Westerfield, and Williams were either B-readers or board-certified radiologists. Drs. Bassali, Fisher, and Marshall are dually qualified readers. The negative readings came from Drs. Castle, Stewart, and Hippensteel, who are B-readers, and Drs. Wiot, Spitz, and Poulos, who are both B-readers and board-certified radiologists. Because the interpretations of this x-ray are evenly divided, I find that it does not establish the existence of pneumoconiosis by a preponderance of the evidence.

The August 5, 1991 x-ray was interpreted as positive by Dr. Robinette, who is a B-reader. However, Drs. Epling, Wheeler, Scott, Fino, Templeton, and Stewart interpreted it as negative. Dr. Epling is a board-certified radiologist; Drs. Fino and Stewart are B-readers; and Drs. Wheeler, Scott, and Templeton are both B-readers and board-certified radiologists. I rely on the readings of the most highly qualified interpreters and find this x-ray negative for pneumoconiosis.

The final positive reading came from the October 17, 1994 x-ray. Drs. Sargent, Pathak, Aycoth, Alexander, and Cappiello found it positive, while Drs. Wiot, Spitz, Wheeler, and Scott interpreted it as negative. Drs. Sargent and Pathak are B-readers, and Drs. Wheeler, Scott, Aycoth,

Cappiello, Alexander, Wiot, and Spitz are dually qualified readers. Relying on the readings of the most highly qualified readers, I find that this x-ray does not to establish the existence of pneumoconiosis by a preponderance of the evidence.

The x-rays taken on October 9, 1980, November 30, 1980, April 28, 1981, February 11, 1982, March 24, 1982, March 26, 1982, September 30, 1982, August 15, 1986, March 31, 1987, June 6, 1990, June 17, 1991, October 8, 1991, February 3, 1993, August 23, 1993, November 22, 1993, March 12, 1994, April 23, 1994, December 5, 1994, December 21, 1994, June 15, 1995, and September 5, 1995 were all interpreted as either negative or unreadable. The vast majority of these readings were by physicians who are either board-certified radiologists or B-readers or both.

Thus, I find that the new x-ray evidence, when viewed in conjunction with all the prior x-ray evidence, does not establish the existence of pneumoconiosis under § 718.202(a)(1).

The autopsy limited to the chest was performed by Dr. Joyce, who found pneumoconiosis. Drs. Naeye and Hutchins, reviewing pathologists, confirmed the finding of pneumoconiosis by autopsy. Drs. Robinette and Castle, who reviewed the autopsy report, also opined that it established the existence of pneumoconiosis. Given the unanimity of these opinions, I find that the autopsy evidence, which is the best evidence for determining the existence of pneumoconiosis, establishes the existence of the disease under § 718.202(a)(2).

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in §§ 718.304, 718.305, or 718.306 are applicable. Since there is no x-ray evidence of complicated pneumoconiosis in the record, § 718.304 does not apply. Section 718.306 is not relevant since the miner must have died before 1978. Section 718.305 is applicable as discussed below.

Pursuant § 718.202(a)(4), Dr. Scott diagnosed pneumoconiosis for the first time in an opinion letter dated July 23, 1999. Dr. Scott never made the diagnosis of pneumoconiosis while he was actively treating the miner. Drs. Forehand, Robinette, and Castle opined in 1999 that pneumoconiosis was present. Although the x-ray evidence does not support the existence of pneumoconiosis, consideration of the autopsy slides and reports led Dr. Castle to change his 1995 opinion and to conclude in his September 22, 1999, report that the miner did have pneumoconiosis. I find the new evidence developed after January 15, 1998, much more probative than that adduced previously, primarily because of the autopsy results. I note, however, that prior opinions and medical records came from Drs. King, Guenthner, Baxter, Garzon, Lapis, Scott, Stewart, Modi, Endres-Bercher, Grady, Jones, Gose, Fosia, Hunter, Sutherland, Robinette, Javed, Sargent, Castle, Rasmussen, and Forehand. Of these, only Drs. Baxter, Grady, Sutherland, Robinette, Rasmussen, and Forehand diagnosed pneumoconiosis. The findings of Drs. King, Guenthner, Lapis, Scott, Modi, Jones, Gose, Fosia, Javed, and Hunter did not address the issue, and the findings of Drs. Garzon, Stewart, Bercher, Sargent, and Castle were negative. Accordingly, I find that the medical opinion evidence, especially that derived from the autopsy, supports a finding of the existence of pneumoconiosis, notwithstanding the negative x-ray evidence pursuant to §718.202. *See Island Creek Coal Co. v. Compton*, ___ F.3d ___, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.2d 22, 24-25 (3d Cir. 1997). The finding of pneumoconiosis establishes a change in conditions and a mistake in a

determination of fact which entitles Claimant to a review of the evidentiary record on the merit's of the miner's claim.

Disability Due to Pneumoconiosis; Death Due to Pneumoconiosis

Section 718.305 provides a rebuttable presumption of death due to pneumoconiosis or total disability due to pneumoconiosis at the time of death if a miner was employed 15 years or more in one or more underground coal mines, the x-ray evidence is negative as to the existence of complicated pneumoconiosis, and other evidence demonstrates the existence of a totally disabling respiratory impairment as defined in § 718.204, provided that the claim was filed on or before January 1, 1982, as the miner's claim was. The miner was employed for at least 24 years as a coal miner. There is no evidence of complicated pneumoconiosis by x-ray, and the evidence under § 718.204 establishes a totally disabling respiratory impairment. Thus the miner was entitled to the rebuttable presumption of § 718.305. The Claimant is not entitled to the presumption because her survivor's claim was filed after January 1, 1982. § 718.305(e).

Section 718.204(c) provides the criteria for determining whether a miner is totally disabled. These criteria are: (1) pulmonary function tests qualifying under applicable regulatory standards; (2) arterial blood gas studies qualifying under applicable regulatory standards; (3) proof of pneumoconiosis and cor pulmonale with right sided congestive heart failure; or (4) proof of a disabling respiratory or pulmonary condition on the basis of the reasoned medical opinions of a physician relying upon medically acceptable clinical and laboratory diagnostic techniques. If there is contrary evidence in the record, all the evidence must be weighed in determining whether there is proof by a preponderance of the evidence that the miner is totally disabled by pneumoconiosis. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-95 (1986).

Four of the pulmonary function studies of record produced qualifying values: the March 31, 1987 study, the pre-bronchodilator study of June 21, 1994, the June 12, 1995 study, and the pre-bronchodilator study of September 5, 1995. I give little weight to the June 21, 1994 study because it was administered by Dr. Modi, who has been convicted of a felony involving fraud. Dr. Castle found the March 31, 1987 and June 12, 1995 studies invalid because Mr. Stanford did not exhale for the requisite time period in all the studies, and there was some hesitation at the onset of exhalation. (DX 144) Because Dr. Castle is a board-certified pulmonary specialist, I give to his opinion substantial weight. The valid and qualifying pre-bronchodilator study from September 5, 1995 is not dispositive. Because the post-bronchodilator study yielded non-qualifying values, and because the previous 12 studies were either invalid or non-qualifying. I find, consistent with prior findings, that the pulmonary function studies do not establish total disability.

The July 9, 1981, September 30, 1982, March 31, 1987, June 20, 1994, and June 21, 1994 blood gas studies of record produced qualifying values. The June 20 and June 21, 1994, studies reported by Dr. Modi, are properly given little weight. Only two of the remaining fourteen studies produced qualifying values. The three most recent studies were not qualifying. Therefore, the prior evidence of arterial blood gas studies did not establish total disability. However, the four most recent blood gas studies, performed since Judge Murty's denial on January 15, 1998, did produce

qualifying values. Since I find that most recent evidence more probative, I find that the miner has established total disability pursuant to § 718.204(c)(2).

Although Drs. Scott and Forehand found cor pulmonale, they did not associate it with right-sided congestive heart failure, as is required by § 718.204(c)(3). Dr. Castle specifically found that Mr. Stanford did not suffer from cor pulmonale. Given his superior credentials in the field of pulmonary medicine, and his thorough review of all the medical evidence of record, I rely on his opinion and find that the miner did not suffer from cor pulmonale with right sided congestive heart failure pursuant to § 718.204(c)(3). *See Scott v. Mason Coal Co.*, 14 BLR 1-38 (1990).

Consistent with Judge Murty's finding, I find that the medical opinion evidence establishes total disability. Of those physicians who provided an opinion on the issue of disability, Dr. Baxter opined that the miner should retire because he would be a danger to himself or coworkers, given his bronchitis, pneumoconiosis, pancreatitis, and cortical atrophy. Dr. Garzon opined in October 1982 that the miner had a significant pulmonary impairment in the nature of chronic bronchitis and that the problem was severe enough to prevent him from returning to his last coal mining work. In December 1986, Dr. Garzon found no evidence of a totally disabling lung condition due to coal mine dust exposure and opined that the miner could return to his last mining duties, from a respiratory standpoint. Dr. Garzon reiterated this opinion in September 1992.

Dr. Stewart opined in December 1986 that the miner did not have a totally disabling lung condition due to coal mine dust exposure, and opined that the miner could return to his last mining duties, from a respiratory standpoint. In September 1992, Dr. Stewart again opined that the miner was not totally disabled from his respiratory impairment, based on pulmonary function and blood gas studies. He opined, however, that the miner was not physically able to return to regular employment because of his recurrent pancreatitis and abdominal pain. He also opined that the miner's respiratory impairment was related to his pancreatitis and abdominal and chest surgery.

Dr. Endres-Bercher opined in March 1987 that the restrictive component of the miner's pulmonary function studies was due to a pleural effusion and the paralyzed right hemidiaphragm, not pneumoconiosis. He based this opinion on his knowledge that these conditions prevent appropriate inflation of the right lung with inspiration, simulating a restrictive lung disease. In October 1991, Dr. Endres-Bercher opined that the miner had a moderately severe obstructive lung disorder which rendered him disabled from work. He did not attribute the disorder to coal dust, however. In September 1992, Dr. Endres-Bercher opined that the miner suffered from pulmonary complications as a result of his organic illnesses, which included recurrent pancreatitis, cardiac insufficiency, and removal of a mediastinal tumor.

In November 1991, Dr. Rasmussen opined that the miner's pneumoconiosis caused no significant loss to his respiratory functional capacity. Dr. Scott opined in September 1992, that the miner had a mild restrictive obstructive pulmonary disease that did not qualify him for black lung disability. Dr. Robinette opined in August 1991 that the miner had a mild respiratory impairment, but by July 1995, Dr. Robinette believed that the miner had developed progressive deterioration of his lung function and that his ventilatory capacity was insufficient to allow his return to coal mine employment. In October 1994, Dr. Sargent opined that from his respiratory system alone, the miner retained the respiratory capacity to perform his last job as a mine foreman. Dr. Sargent opined that

the miner's restrictive impairment was not consistent with pneumoconiosis and could be accounted for by his obesity, pancreatitis, and surgery. Dr. Forehand examined the miner in June 1995 and opined that the miner was totally disabled by his respiratory impairment which arose at least in part from his 32 years of coal mine employment.

Since the prior denial, Drs. Naeye and Hutchins found that lung impairment existed, but did not ascribe a degree of severity to it. Dr. Robinette opined that the miner was totally disabled by his respiratory impairment, and Dr. Castle also found him totally disabled from a respiratory standpoint. These opinions are well documented and reasoned. They are supported by the new blood gas studies and the physical findings. The new evidence is corroborated by the prior medical opinion evidence from Drs. Baxter, Garzon, Bercher, Stewart, Robinette, and Forehand. Consequently, I find that the miner was totally disabled by a respiratory or pulmonary condition pursuant to § 718.204(c)(4), and that as a consequence, he is entitled to the rebuttable presumption found at § 718.305.

The Employer may rebut that presumption by establishing that the miner did not have pneumoconiosis or that his respiratory or pulmonary impairment did not arise out of coal mine employment, but not on the basis of evidence demonstrating the existence of a totally disabling obstructive respiratory or pulmonary disease of unknown origin. The miner's pneumoconiosis was established by the autopsy evidence. Therefore, to rebut the presumption, the Employer must prove that the miner's respiratory or pulmonary impairment did not arise out of coal mine employment.

A review of the medical opinions prior to Judge Murty's January 15, 1998, denial shows that Dr. Baxter opined that the miner should retire because he would be a danger to himself or coworkers, given his bronchitis, pneumoconiosis, pancreatitis, and cortical atrophy. Dr. Garzon found no evidence of a totally disabling lung condition due to coal mine dust exposure, and opined that the miner could return to his last mining duties from a respiratory standpoint. Dr. Endres-Bercher opined that the restrictive component of the miner's pulmonary function studies was due to a pleural effusion and the paralyzed right hemidiaphragm, not pneumoconiosis. He based this opinion on his knowledge that these conditions prevent appropriate inflation of the right lung with inspiration, simulating a restrictive lung disease, and that the miner suffered from pulmonary complications as a result of his organic illnesses which included recurrent pancreatitis, cardiac insufficiency, and removal of a mediastinal tumor. Dr. Stewart opined that the miner was not physically able to return to regular employment because of his recurrent pancreatitis and abdominal pain, not because of any respiratory problem, which Dr. Stewart related to his pancreatitis and abdominal and chest surgery. Dr. Rasmussen opined that the miner's pneumoconiosis caused no significant loss to his respiratory functional capacity. Dr. Sargent opined that the miner's restrictive impairment was not consistent with pneumoconiosis, and could be accounted for by his obesity, pancreatitis, and surgery. Dr. Scott did not provide an opinion on this issue. Dr. Robinette opined that the miner's respiratory impairment was due to coal workers' pneumoconiosis. Dr. Forehand opined that the miner was totally disabled by his respiratory impairment which arose at least in part from his 32 years of coal mine employment.

I give less weight to the opinions of Drs. Robinette and Forehand, although they are well documented and based on a review of some medical evidence, because the pulmonary function studies and blood gas studies they relied upon were non-qualifying and those results were not reconciled with their conclusions. *See Hopton v. US Steel Corp.*, 7 BLR 1-12 (1984). Furthermore,

they did not discuss whether the miner's other, very significant conditions, contributed to his respiratory impairment. Also, Dr. Forehand stated his opinion in equivocal terms of the respiratory impairment "appear[ing]" to have arisen, at least in part, from coal mine employment. *See Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988).

I give more weight to the opinions of Drs. Endres-Bercher, Baxter, Stewart, and Sargent, who attributed Claimant's respiratory disability to his pancreatitis, paralyzed hemidiaphragm, and surgeries. Their opinions are logical, given Claimant's medical history and the worsening of these problems with time. Their opinions are also supported by the limited extent of the miner's pneumoconiosis and the later medical opinion discussed below. The opinions of Drs. Garzon and Rasmussen also merit weight because they are well documented and reasoned. *See Perry v. Director, OWCP*, 9 BLR 1-1 (1986). Consequently, I find that the employer has rebutted the presumption that the miner's total disability and death were due to pneumoconiosis pursuant to § 718.305.

The new medical opinions bearing on this issue come from Drs. Naeye, Hutchins, Forehand, Robinette, and Castle. Dr. Forehand opined that a pulmonary function study evinced a totally disabling obstructive-restrictive respiratory impairment typical of pneumoconiosis. Dr. Robinette opined that the miner's pneumoconiosis was severe enough to cause a respiratory impairment which would have rendered him unable to work as a miner. However, Drs. Naeye and Hutchins opined that the lesions establishing pneumoconiosis were too small and few in number to have caused any lung function abnormality, and that the pneumoconiosis was far too mild to have prevented the miner from returning to his last mining job. Dr. Naeye specifically opined that, of itself, the miner's lung impairment was due to a paralyzed right hemidiaphragm which was not due to pneumoconiosis. Dr. Hutchins asserted that the miner's respiratory impairment was due to congestive heart failure due to ischemic heart disease, and not pneumoconiosis. Dr. Castle attributed the miner's totally disabling respiratory impairment to recurrent pneumonia with pleural effusions, thoracic surgery with injury to the right phrenic nerve and paralysis of the right hemidiaphragm, obesity, and congestive heart failure, but not to pneumoconiosis.

I find Dr. Forehand's opinion to be equivocal. *See Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988). His opinion states that the respiratory impairment he found on spirometry is "typical of pneumoconiosis." He also relied upon a pulmonary function study that does not appear of record, thus rendering his opinion not well documented to that extent. *See Minton v. Director, OWCP*, 6 BLR 1-670 (1983). Furthermore, his insistence and reliance upon the miner's having cor pulmonale was contradicted by Dr. Castle's contrary opinion. Because I have credited Dr. Castle's opinion on this issue over Dr. Forehand's, as noted above, I find this reliance further detracts from the credibility of Dr. Forehand's opinion. Dr. Robinette's opinion merits some weight because it is based on a review of the medical record, because it is his second review of the medical records, and because he has impressive credentials. However, I find the opinions of Drs. Hutchins, Castle, and Naeye to be more probative because the several of them have good credentials and their opinions are well reasoned.

The opinions of Drs. Naeye and Hutchins merit great weight because both physicians are board-certified pathologists. They examined the autopsy slides, and based on that examination

opined that the miner's pneumoconiosis was not severe enough to have contributed to his pulmonary or respiratory impairment. Their opinions were also based on partial reviews of medical records. For these reasons, I find their conclusions well documented and well reasoned. I place the most weight on Dr. Castle's opinion. He is a board-certified specialist in pulmonary disease, and he provided a second extensive review of the medical evidence. His opinion that paralysis of the right hemidiaphragm was one of the causes of disability is supported by Dr. Naeye's finding to the same effect. His conclusion that congestive heart failure was another cause of the totally disabling respiratory impairment is supported by Dr. Hutchins's finding to the same effect. His attribution of the disability to pneumonia with pleural effusions is supported by many hospital records and x-ray reports.

Finally, I find persuasive the fact that throughout the miner's myriad hospitalizations, it was repeatedly found that he suffered from pancreatitis, angina, peptic ulcer disease, arteriosclerotic heart disease, and diabetes mellitus. He rarely had any significant pulmonary condition that was diagnosed upon physical examination, and any pulmonary condition he had apparently did not prevent his undergoing surgery just a year before his death. His treating physician of many years did not attribute any pulmonary impairment to pneumoconiosis when he was assessing the miner's deteriorating condition for treatment; rather he waited until after the miner had died. Consequently, his opinion has little credibility in this regard. For these reasons, I find that a preponderance of the evidence establishes that the miner's totally disabling respiratory impairment was not due to pneumoconiosis. The prior medical evidence of record supports this finding. Consequently, I conclude on this basis also that the employer has rebutted the presumption pursuant to § 718.305.

Causation

Under § 718.203, I find that the miner's pneumoconiosis was caused at least in part by his coal mine employment, because he has established more than ten years of coal mine employment; the relationship is thus presumed; and the presumption is not rebutted because the weight of the medical evidence does not establish any cause for the miner's pneumoconiosis other than coal mine employment.

In addition to establishing the presence of pneumoconiosis, and that such pneumoconiosis arose out of coal mine employment, it must be proved by a preponderance of the evidence, that the miner is totally disabled due to pneumoconiosis. *See Gee v. W.G. Moore & Sons*, 9 BLR 1-4 (1986). To establish total disability, the miner must prove that his pneumoconiosis prevents him from engaging in either his usual coal mine work or comparable and gainful work as defined in § 718.204. In this regard, a miner must establish "by a preponderance of the evidence that his pneumoconiosis was at least a contributing cause of his totally disabling respiratory impairment." *See Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38, 14 BLR 2-68, 2-76 (4th Cir. 1990); *Scott v. Mason Coal Co.*, 14 BLR 1-37, 1-39 (1990). I have found that the miner established total disability pursuant to both § 718.204(c)(2) and § 718.204(c)(4). However, I have found that the Employer rebutted the presumption found at § 718.305, by proving that the miner's totally disabling respiratory impairment was not due to pneumoconiosis. In so doing I have determined that the Claimant has not proved that the miner's pneumoconiosis was at least a contributing cause of his totally disabling respiratory impairment. Accordingly, the miner's claim must be denied.

Death Due to Pneumoconiosis

Since this claim involves a survivor's claim filed after June 30, 1982, benefits are payable only if the miner's death was due to pneumoconiosis pursuant to the following criteria:

1. Where competent medical evidence established that the miner's death was due to pneumoconiosis, or

2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or

3. Where the presumption set forth at Section 718.304 is applicable.

4. However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death.

§ 718.205(c). Pneumoconiosis substantially contributes to death if it serves to "hasten" death in any way. *Brown v. Rock Creek Mining Co.*, 996 F.2d 812 (6th Cir. 1993); *Grizzle v. Pickands Mather and Co.*, 994 F.2d 1093, 17 BLR 2-123 (4th Cir. 1993); *Peabody Coal Co. v. Director, OWCP (Railey)*, 972 F.2d 178, 16 BLR 2-121 (7th Cir. 1992); *Shuff v. Cedar Coal Co.*, 967 F.2d 977, 16 BLR 2-90 (4th Cir. 1992), *cert. denied*, 113 S.Ct. 969 (1993); C.F.R. § 718.205(c); *Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 13 BLR 2-100 (3rd Cir. 1989).

Dr. Joyce, who performed the autopsy, listed the cause of death as multi system failure secondary to hypotension resulting from cardiac decompensation secondary to severe coronary artery disease. Dr. Mitchell listed the cause of death as congestive cardiomyopathy and arteriosclerotic cardiovascular disease, with other significant factors being renal failure, diabetes mellitus, chronic pancreatitis, and hypothyroidism. Dr. Naeye opined that the miner's pneumoconiosis was far too mild to have hastened his death in any way. Dr. Hutchins opined that neither pneumoconiosis nor coal dust exposure played any role in hastening the miner's death. Dr. Castle opined that death was due to multi-organ failure due to cardiac decompensation related

to an acute myocardial infarction in the face of severe coronary artery disease and cardiomyopathy. He added that death was neither caused by, contributed to by, nor hastened by pneumoconiosis. Dr. Scott, however, opined that pneumoconiosis contributed to the miner's death. Dr. Forehand testified that pneumoconiosis led to cor pulmonale which contributed to the miner's death, which was the direct result of multiorgan failure. Dr Robinette opined that pneumoconiosis at least partially contributed to the miner's death.

I give some weight to Dr. Scott's opinion linking the miner's death to pneumoconiosis because of his status as the miner's treating physician who was familiar with his condition over a number of years. *See Schaaf v. Matthews*, 574 F.2d 157, 160 (3d Cir. 1978). However, I do not

find it persuasive. The abundance of medical records, both from the hospital and in his office progress notes, disclose, as previously noted, that Dr. Scott never made the diagnosis of pneumoconiosis until an opinion was solicited by the Claimant in this case. Moreover, Dr. Scott did not explain how the miner's pneumoconiosis could have contributed to the miner's death. Dr. Forehand's opinion is belied by his reliance on cor pulmonale as a condition suffered by the miner. Since Dr. Forehand relied on a conclusion that the miner's pneumoconiosis progressed into cor pulmonale which then contributed to the miner's death, the opinion unpersuasive.. I have relied on Dr. Castle's reasoned opinion to conclude that the miner did not suffer from cor pulmonale. Dr. Castle's opinion is better reasoned and documented, and his credentials as a pulmonary specialist are better than Dr. Forehand's credentials.

Although Dr. Robinette's opinion is well reasoned, and his credentials impressive, and even though he considered all the evidence of record, I do not find his opinion as persuasive as the aggregate opinions of the three well qualified pathologists who examined and assessed the evidence from the autopsy, and Dr. Castle. Dr. Joyce's opinion is persuasive because he is a board-certified pathologist, and was the autopsy prosector who had the most direct and comprehensive chance to evaluate the miner's pulmonary condition first hand. The opinions of Drs. Hutchins and Naeye are persuasive because they are board-certified in pathology; they had the advantage of reviewing other medical evidence as well; and their opinions are well documented and reasoned. *See Wetzel v. Director, OWCP*, 8 BLR 1-139 (1985). Dr. Mitchell's opinion is persuasive because he attended the miner during some hospital stays and thus had an extensive opportunity to observe his failing medical conditions. I also place great weight on Dr. Castle's opinion because of his command of the medical evidence of record and his expertise in pulmonary medicine. His opinion is consistent with those of the pathologists, and I find his reasoning to be cogent and logical, given the miner's serious medical conditions such as pancreatitis, coronary artery disease, and renal failure, as compared with his relatively mild pulmonary conditions.

For these reasons, the Claimant has not established that the miner's death was due to pneumoconiosis, that his pneumoconiosis a substantially contributing cause of death, or that his pneumoconiosis hastened the miner's death in any way, and so her survivor's claim for benefits must be denied.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only if benefits are awarded. Since benefits are not awarded in this case, the Act prohibits the charging of any fee for representation in pursuit of the claims before this tribunal.

ORDER

The claims of the deceased miner, Worley C. Stanford, and his surviving spouse, Elletha Stanford, for black lung benefits under the Act are denied.

_____
EDWARD TERHUNE MILLER
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.